FREEDOM COUNSELING SERVICES

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Medical Form

Patient's Name _____ Date of Birth_____

PPD Date Given: _____ Date Read: _____ Results: _____(mm)

Is the PPD (TB Test) Negative? YES NO

Does this person require medical detoxification? YES NO

Does this person show signs or symptoms of contagious disease? YES NO

Does this patient appear to be healthy and appropriate for a non-medical program? YES NO

Current Medications

Name of Medication:	For:	Dosage:
1.		
2.		
3.		
4.		
5.		

Examiner's Name (Print): _____ Phone: _____

Examiner's Signature: _____ Date: _____